Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS SPINE & SURGICAL HOSPITAL
18600 NORTH HARDY OAK BLVD.
SAN ANTONIO TX 78247

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Carrier's Austin Representative Box
Box Number 19

Respondent Name
AMERICAN GUARANTEE & LIABILITY

MFDR Received Date
JUNE 9, 2008

MFDR Tracking Number
M4-08-6255-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is our position, based on the Texas Administrative Labor Code 413.011, charges billed should ' have a fair and reasonable reimbursement which is consistent with the criteria of [sic] ensures that similar procedures provided in similar circumstances received similar reimbursement…' We do not feel that the above guidelines were utilized for the services of August 22, 2007 for [injured employee] and included copies of recent Workman Compensation Explanation of Benefits reimbursements showing fair and reasonable compensation for the same procedure performed in our facility for other patients during this time period"

Amount in Dispute: $17,175.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Because Requestor has failed to prove that the reimbursement received is not fair and reasonable, Requestor is not entitled to further reimbursement."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Ste. 1000, Austin, TX 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2007	Outpatient Surgery	$17,175.04	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.

3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on June 9, 2008.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 226 – Included in global charges.
   - 351 – No additional reimbursement allowed after review of appeal/reconsideration.
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - 770 – Complex Bill Review
   - 793 – Reduction due to PPO contract.
   - 97 – Payment is included in the allowance for another service/procedure.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Findings

1. The insurance carrier reduced or denied disputed services with reason codes 45 – "Charges exceed your contracted/legislated fee arrangement" and 793 – "Reduction due to PPO contract." On Janaury 20, 2011 the Division requested a copy of the contract between the information/voluntary network and The Spine Hospital of South Texas as described by Texas Labor Code § 413.011(d-1)(2) and documentation to support that THe Spine HOpsital of South Texas was notified in accordance with 28 Texas Administrative Code §133.4. The insurance carrier's representative submitted a response to the Divisions request stating, "The Carrier understands the Medical Review Division would like a copy of the contract that was used for purposes of reviewing the bill underlying the present dispute. The Carrier will use its best efforts to provide the Medical Review Division with a copy of the contract as soon as possible." As of September 24, 2012 the Division has not received a copy of the contract in question. Therefore, the above denial/reduction reason is not supported and the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(F)(i), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "a description of the health care for which payment is in dispute." Review of the submitted documentation finds that the requestor has not provided a description of the health care for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(i).
5. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement / rationale for increased reimbursement from the *Table of Disputed Services* asserts that "We do not feel that the above guidelines were utilized for the services of August 22, 2007 for [injured worker] and included copies of recent Workman Compensation Explanation of Benefits reimbursement showing fair and reasonable compensations for the same procedure performed in our facility for other patients during this time period."
   - In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are

for services that are substantially similar to the services in dispute. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 27, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.